HEALTH DEPARTMENT AUTHORIZATION FOR MEDICAL SERVICES AND PARTICIPATION CONSENT

This certifies that_____ may participate in the Alachua County Health Department medical services program. The Health Department program offers the following services: Medical History, Medical Examinations, Nutritional and Health Education, and limited laboratory diagnostic screenings. The Alachua County Health Department utilizes a clinic arrangement with several levels of providers. I understand that with certain procedures, person other than a licensed physician may carry out treatments and other activities, but all such persons will be fully trained in their field and directed by a licensed physician. By signing below I am giving consent for all present and future treatments and medication administered to me, my minor or ward by the Alachua County Health department.

I understand that I might be referred for specialty care, lab tests, and diagnostic studies or for hospitalization for a higher level of care. If this is needed I will be responsible for payment of any such services rendered. I understand that the Alachua County Health department will provide limited basic laboratory diagnostic tests annually to me. The cost of additional lab tests and/or radiographic or other diagnostic tests will be the patient's responsibility. Medications are not provided by the health department.

I have read and understand this consent form and I hereby authorize payment of medical benefits to the undersigned physician/supplier for services described on all claims submitted on my behalf. I also request benefits to be paid to the party who accepts assignments as listed on the claim. I will be responsible for paying all insurance co pay's and unpaid balances by my insurance carrier. I understand that the Department of Health financial policies require that my account be referred to a collection agency after three billing cycles with an unpaid balance.

Signed_____Date_____

Relationship_____Witnessed_____

I, _____consent to statements for all services to be mailed to the address provided below.

Client label or _____

Street Address City State Zip

Client or Guardian Signature_____

REV 06-27-13